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PREVENTING CHILD ABUSE AND NEGLECT DEATHS: THE IDENTIFICATION AND MANAGEMENT OF HIGH RISK CASES

by

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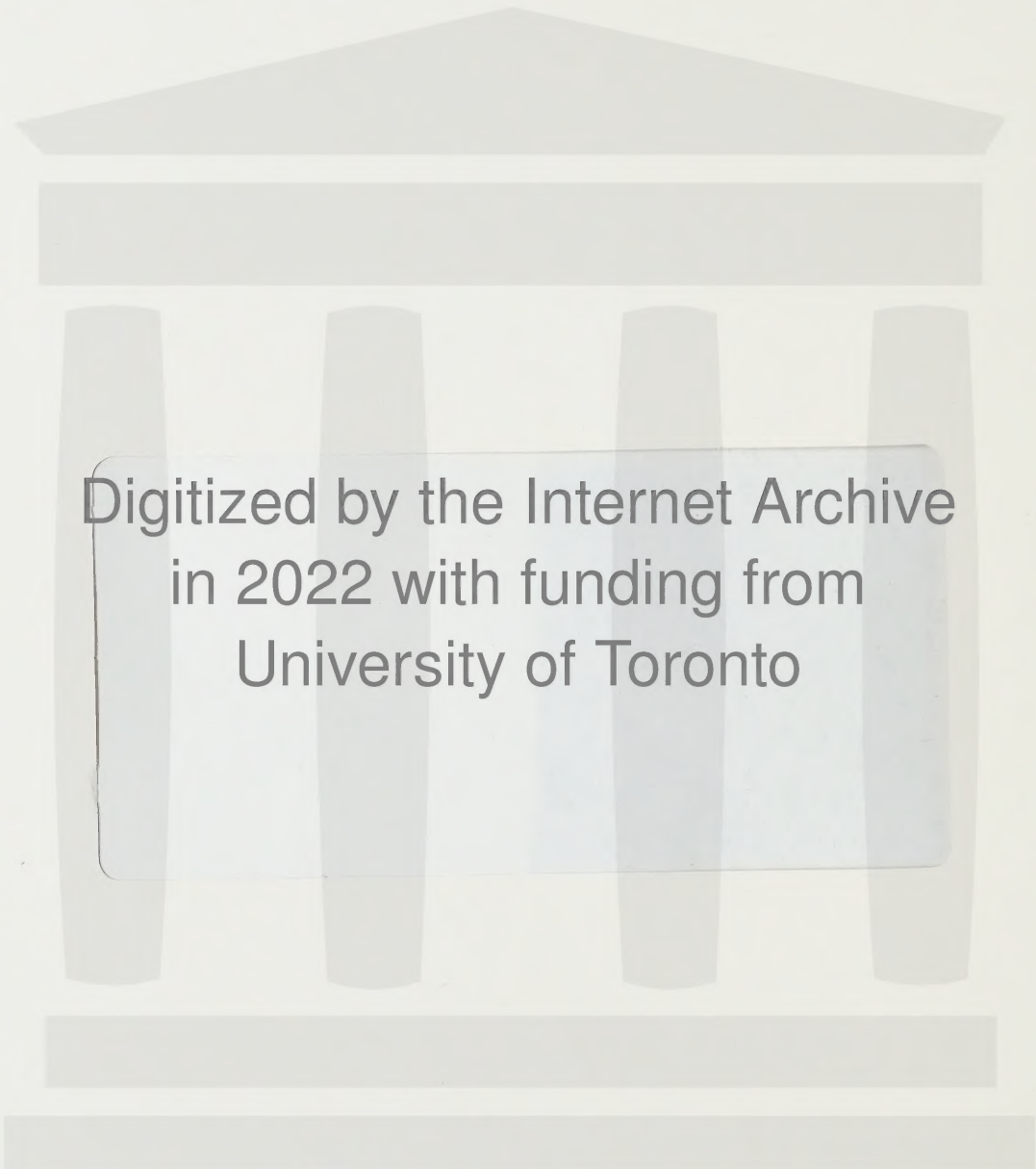

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CYRIL GREENLAND

Summary

Based on an international literature review and study of child abuse deaths in the USA, Canada and the UK, the question of preventing child abuse and neglect deaths is considered. Guidelines are suggested for identification and assessment of children at risk.

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Introduction

Although deaths due to child abuse are fortunately rare, when a child under the supervision of a child protection agency is killed, the tragedy is usually exploited by the news media. This results in the transfer of public concern and outrage from the assailant who killed the child to the social workers who failed to protect the child. The extreme vulnerability of social workers to this kind of public humiliation has unfortunate consequences which go far beyond the individuals concerned. It leads, for example, to defensive social work. This, like the practice of defensive medicine, is more concerned with protecting institutions and professional reputations than with meeting the needs of children and their families.

Balancing the danger of leaving abused children at home against the harm of separating them precipitously from their parents is an awesome responsibility for child protection agencies. Since an element of risk-taking is unavoidable, the search for more effective ways of identifying and managing high risk cases is, or should be, an indispensable feature of child welfare practice. This issue is addressed in the research reported here, which is primarily concerned with preventing, or at least reducing, the incidence of child abuse deaths.

Sources of data

This research is a continuation of a previous study[1] of lethal family situations. In addition to an international review of the literature, including an analysis of the published US data, the research was based on two cohorts of child abuse deaths. Data based on 100 child abuse or neglect (CAN) deaths from Ontario, 1973-1982, involved an analysis of cases provided by the Chief Coroner's office. The UK data consisted of an analysis of 68 deaths. This included 30 official reports on CAN deaths involving children under the supervision of a child protection agency; data on 33 deaths known to the National Society for the Prevention of Cruelty to Children, and five CAN deaths reported to an Area Review Committee.

In the interest of brevity, the following section on incidence refers only to the most recent studies from the USA, UK and Canada. For the same reason, observations on the characteristics of the victims and perpetrators are limited to the 100 Ontario deaths. It is, however, important to emphasize that in many respects the USA, UK and Canada data tell similar stories.

Incidence

In many otherwise excellent studies, the CAN fatalities are expressed as a proportion of the number of confirmed cases on the Child Abuse Register. This ignores the fact that fashions in the definition of abuse change over time and in different locations. Bearing this in mind, the most recent community-based studies of CAN deaths in the USA show that the estimated fatality rates range from 1.5 per 1000 reported cases[2] to 12 per 1000.[3] Since these figures are well below the five percent of fatalities in the severe abuse cases suggested by Helfer and Pollock,[4] it can be assumed that earlier estimates of CAN deaths were exaggerated.

The estimated incidence of CAN deaths in the UK has also been drastically revised. According to a recent report,[5] the somewhat wild figure of two child abuse deaths per day has been reduced to 44-74 per year in England and Wales. Although accurate data are still hard to find, it has been suggested that owing to more effective child protection services, the risk of serious injuries and deaths due to child abuse is declining in the UK.[5]

In order to provide a more secure foundation for estimating the incidence of CAN deaths in Ontario, the number of fatalities reported by the Chief Coroner was calculated as a proportion of the population of children at risk. From this perspective the incidence of CAN deaths, averaging ten per year from 1973 to 1982, is relatively stable. Recorded annually in Ontario Vital Statistics, the CAN deaths are part of a much larger group of infant deaths attributed to 'accidents and violence'. Looking specifically at the fatalities in the nought to four year age range, it appears that over a period of ten years, only between four and eight percent of the deaths were due to abuse and/or neglect. While this is still a matter for serious concern, it cannot be said that child abuse in Ontario is a major cause of infant mortality. In Canada, as in the USA and the UK, the foremost maimers and killers of our children are motor vehicles and domestic accidents.

The victims

The risk of death due to CAN is highest in the first year of life. The Ontario data, confirmed by most other studies, show that well over half of the victims, (60 percent females, 53.7 percent males) died before the age of 12 months. An additional 25 percent, (19 percent females, 29.6 percent males) died before the age of two years. Only five percent of the victims were over the age of five years. This suggests that if these vulnerable children could be identified and protected up to the age of four, the risk of death due to child abuse would be considerably reduced.

The difficulty of identifying high risk children is to some extent simplified by the fact that about half of them, in the Ontario cohort, were already known to a child protection agency. Over 60 percent of the victims had been previously abused and their injuries treated by physicians. Therefore, a previous history of abuse to the victim or siblings and unexplained or poorly explained injuries in infancy, should be recognized as vital elements in the assessment of risk.

Equally important is the finding that almost half (47 percent) of the infant victims were at or below the third centile for height or weight. Sixteen of them, (10 males and six females), being below the third centile for height and weight, were clearly suffering from non-organic failure to thrive. This alone places them into a high risk category. Evidence of a previous injury before the age of five years and being stunted in height, weight or both, should alert and alarm the helping professionals.

An unexpected finding, rarely reported in the literature, is that abused children, including young infants, are able to express 'warning' or 'help-seeking' behaviour. Here are three typical examples: Kim, aged six months, who had previously been abused by her mother, was observed by two social workers and a policeman to be resting comfortably in the arms of her aunt. When her mother tried to pick her up, Kim squirmed, resisted and was exceedingly apprehensive. At the age of 19 months Kim was killed by her mother.

Within a few weeks of his birth, Jeff was seriously injured by his mother. After surgery and a brief stay in a foster home, Jeff was returned to his mother. While under the supervision of a child protection agency, Jeff showed signs of further abuse and neglect. A new social worker, on her second home visit, recorded that when she got up to leave, Jeff, then aged 14 months, 'cried uncontrollably'. When he was three years old, Jeff sustained serious internal injuries at the hands of his mother.

After being cared for by her aunt and uncle from the age of four months, Maria, aged six years, was returned to her mother and step-father. They were known to neglect their own children. Concerned neighbours reported to the child protection agencies that Maria was being abused and neglected. Maria's 'help-seeking' behaviour consisted of running away from home, half-dressed, early in the morning and begging an aunt for protection. Shortly before her eighth birthday, Maria was killed by her step-father.

Although it is often impossible to determine if abuse provokes disturbed behaviour in children or if disturbed behaviour provokes abuse, there can be no doubt that a high proportion of abused children are extremely difficult to rear. Premature infants, for example, appear to be extremely vulnerable to abuse and neglect. The clinical assessment of these and other battered children[6,7,8] indicates the presence of severe behaviour disorders which adults, especially parents, find very disturbing. Failure to recognize the extent to which the child's behaviour may contribute to the abusive situation may have disastrous consequences.

Perpetrators

The suspected perpetrators were identified in 98 out of the 100 Ontario cases. Forty-three of them were females and 36 males. In 19 cases, both parents or partners were jointly responsible for the child's death. Natural parents were the perpetrators in 63 percent of the deaths; mothers were involved in 38 deaths, fathers in 13 deaths and both parents in 12 deaths. Acting alone or together with the mother, 'common-law' partners or boyfriends

were responsible for 25 deaths. Baby-sitters, ranging in age from 12 to 40 years, were responsible for nine deaths.

Young, single or separated mothers were responsible for 21 deaths. A domestic situation characterized by a teenage pregnancy, poverty and social isolation was frequently observed in this group. A current pregnancy or post-partum state increases the risk to children in these vulnerable families.

Many of the poor and isolated young mothers were exploited by unstable men who established themselves in the home as 'common-law' partners. Very young children, left in their care, have a high risk of being severely abused or killed.

Data on the perpetrators' socio-economic status were difficult to obtain. Where this information was available, there could be no doubt that the usual manifestations of poverty, low educational achievement, being unskilled or unemployed, poor health and inadequate housing, were present in the vast majority of cases. White collar or professional occupations were recorded for only six of the Ontario perpetrators.

Identification and management of high risk cases

Once an adult has seriously injured a child, if the underlying social and emotional stresses are not relieved, the risk of repetition is very high. This is particularly true for young parents who lack social skills and social support. It also follows that seriously abused children, returned to the same environment, have a risk of further injury. As a general rule it can be said that with severe injuries, involving broken bones or fractured skulls, the younger the child, the greater the risk of death.

Unlike the most extreme cases, which present little difficulty, the marginal cases, where the facts are in doubt, defy simple rules. Assessments must therefore take into account a wide range of personal and socio-situational factors. The victim's developmental status and medical history are highly relevant. Detailed information about the perpetrator's background, parenting capacity, abuse of alcohol and drugs and history of criminal assaultive behaviour is obviously necessary. Equally important is information about the availability and the use of social, family and professional support systems.

The quality of the community's response to child abuse should also be considered as part of the assessment. The involvement of incompetent physicians, closed child protection agencies and inexperienced social workers obviously contributes to the risk of further abuse and neglect.

The failure of child protection agencies to respond to warnings by neighbours and concerned relatives contributed to several well publicized CAN deaths in the UK and Ontario. Another source of concern is the failure of professionals to respond adequately to the help-seeking behaviour of desperate parents. Depressed mothers, for example, frequently seek medical help for their children. An insensitive physician, who does little more than prescribe a tranquilizer, is writing a prescription for disaster.

In brief it can be stated that the effective management of high risk cases involves six main elements, including the following:

- The assignment of a professionally competent and experienced social worker to help the family and to protect the child.

- After the initial crisis has been contained, a comprehensive assessment of the total family situation must be completed and used as a guide to intervention.

- The development by the child protection agency in co-operation with the parents, concerned relatives and neighbours, of clear and manageable goals for supporting the family, reducing stress and protecting the children.

- Since high risk cases almost invariably involve a host of social agencies, including the police, the child protection agency must take the initiative in establishing an interdisciplinary case-management committee.

- The abused child, whether s/he remains at home or not, will probably need specialized developmental assessment and treatment.

- The courts, if involved, must be made aware of Henry Kempe's dictum, that if a child is not safe at home it cannot be protected by casework.[9]

Conclusion

This study of CAN deaths indicates the need for some drastic changes in the provision of child protection services. There is, for example, no doubt that the lack of an interdisciplinary approach and failures in interprofessional communication, place the lives of 'at risk' children in jeopardy.

Once identified, 'high risk' generates anxiety among the helping professionals. This is manifested either in paralysis and the loss of professional objectivity or in multiple panic responses, which serve only to increase the parents' hostility and despair. Sporadic casework, without tangible improvements in the family situation, is ineffective in protecting abused and neglected children.

The good news is that, since child protection workers are becoming familiar with the psychological studies of abused children, attention is, at last, being paid to the role of the child in provoking abuse. Without blaming the victim, it is possible to recognize the extent to which many abusive parents need specialized help in coping with very difficult children.

Finally, it is important to recognize that improved techniques for identifying and managing high risk children, while ensuring physical survival, will not heal their emotional wounds. For this reason the professional community must make the public and government agencies aware of the need for

special programmes to meet the social and emotional needs of battered and neglected children and their siblings. Providing these services today may be the only effective way of preventing child abuse deaths tomorrow.

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